

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1-1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05250

05241

1. DECEASED-NAME (Type or print) <b>EDWARD</b>			First <b>JAMES</b>			Middle <b>BERRY</b>			Last <b>BERRY</b>			2a. DATE OF DEATH Month <b>4</b> Day <b>1</b> Year <b>69</b>			2b. HOUR <b>6:00</b> M		
3. SEX <b>Male</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH <b>11/28/99</b>			6. AGE (In years last birthday) <b>69</b> YRS.			IF UNDER 1 YEAR MONTHS OAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>CARROLL</b>						Md.		
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>plumber</b>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore Co</b>			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>7824 Eastern Avenue</b>					
14. FATHER'S NAME <b>JAMES</b>			First <b>E.</b>			Middle <b>BERRY</b>			15. MOTHER'S MAIDEN NAME First <b>MARY</b>			Middle <b>C.</b>			Last <b>McCABE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>220-54-7586-T</b>			17. INFORMANT <b>Hospital records</b>						Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>011.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Tuberculosis, minimal, inactive</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b> <b>yrs.</b> <b>yrs.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Dementia praecox, hebephrenic type</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that <del>(I)</del> (this hospital) attended the deceased from <b>8/14</b> , 19 <b>26</b> , to <b>4/1</b> , 19 <b>69</b> , that <del>(I)</del> (we) last saw the deceased alive on <b>4/1</b> , 19 <b>69</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> (we) (did) <del>(did not)</del> view the body after death.																	
22b. SIGNATURE <b>Moises Sucholeiki M.D.</b>			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>4/1/69</b>								
22d. PHYSICIAN'S NAME (Type) <b>Moises Sucholeiki, M. D.</b>			22e. ADDRESS <b>Springfield State Hospital</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>4-5-1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore County, Maryland</b>								
24. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</b>			ADDRESS			25a. RECEIVED BY REGISTRAR DATE <b>APR 3 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								

05250



Salisbury County, Maryland

State of Maryland, 1801-1802

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05251		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05242	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <u>George HENRY Black Jr</u>			2a. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1969</u>			2b. HOUR <u>9:5A</u> M	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>MAY 2, 1912</u>		6. AGE (In years last birthday) <u>56</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Carroll</u> Md.	
10. CITY OR TOWN OF DEATH <u>Manchester</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>RD#1</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Farmer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Carroll</u>		13c. CITY OR TOWN <u>Manchester</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <u>RD#1, Balto Pike</u>		14. FATHER'S NAME First Middle Last <u>George HENRY Black</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Virginia Myers</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <u>No</u>		16b. SOCIAL SECURITY NO. <u>219-36-1094</u>		17. INFORMANT <u>Gladys Black</u>		Address <u>Manchester Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary HEART Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u> <u>Feb 1968</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) _____		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) _____		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 4</u> , 19 <u>67</u> , to <u>April 8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Joseph E. Bush MD</u>				22c. DATE SIGNED <u>4/8/69</u>		22d. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>	
22e. ADDRESS <u>DAMPSTEAD Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/11/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Manchester Md Carroll Co</u>	
24. FUNERAL DIRECTOR <u>Wayne V. Kemworthy</u>				25a. REC'D BY REGISTRAR <u>Manover, Penna</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>APR 14 1969</u>							

MEDICAL CERTIFICATION

1923

RECEIVED

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VR A15  
45M - 1-1-69

05252		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05243			
1. DECEASED-NAME (Type or print) First Middle Last Homer Alonzo BLACK						2a. DATE OF DEATH Month Day Year April 19, 1969		2b. HOUR MIN. 3:30 PM	
3. SEX male		4. RACE white		5. DATE OF BIRTH 11-23-02		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived or if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Mt. Savage		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route #1, Box 83	
14. FATHER'S NAME First Middle Last Newton S. Black				15. MOTHER'S MAIDEN NAME First Middle Last Rettie Parks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-10-1278		17. INFORMANT Records				Address Springfield State Hospital, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Fibro-granular Pulmonary Tuberculosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Tuberculous Pericarditis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years mos. or years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>CBS assoc. with disturbance of metabolism, growth or nutrition, presenile brain disease, without qualifying phrase.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>7-25-67</u> , 19____, to <u>4-19-69</u> , 19____, that (I) (we) last saw the deceased alive on <u>4-19-69</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Antonius Glahn</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-19-69</u>		
22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-19-69		23c. NAME OF CEMETERY OR CREMATORY St. George Cemetery		23d. LOCATION (City or Town) (County) (State) Mt. Savage, Md.			
24. FUNERAL DIRECTOR Joseph R. Durst, Frostburg, Md. 21532					25a. REC'D BY REGISTRAR DATE APR 24 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		





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VR A15 (4)  
30M REV. 1/68

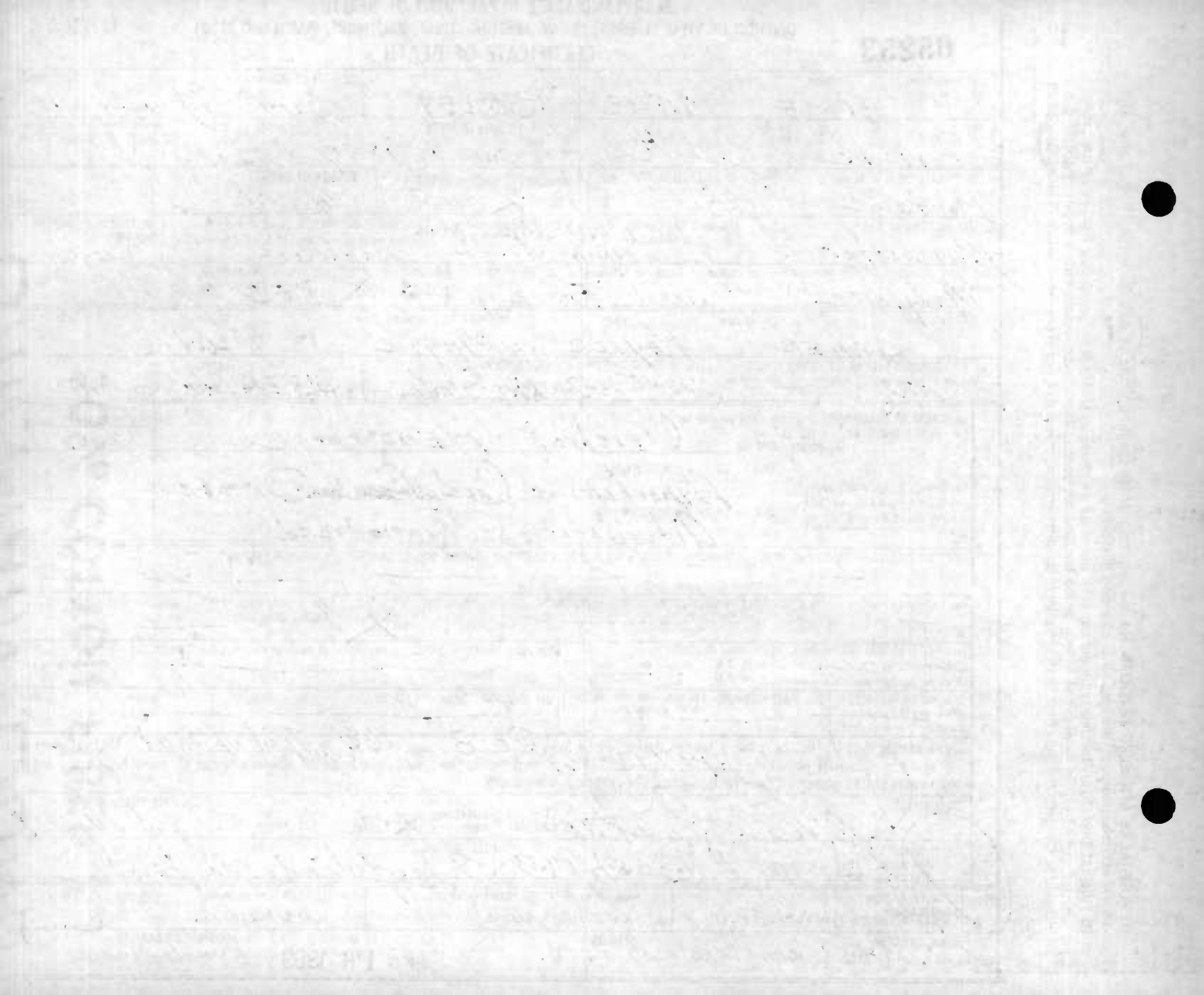
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05253

05244

1. DECEASED-NAME (Type or print) First Middle Last Alice Marie Bosley			2a. DATE OF DEATH Month Day Year April 14 1969			2b. HOUR MIN. 11P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan 17, 1897		6. AGE (In years lost birthday) YRS. MONTHS DAYS 72 12 12	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.	
10. CITY OR TOWN OF DEATH Winchester.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Longwood Nursing Home 12801 Main Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Finksburg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER RFD #1		14. FATHER'S NAME First Middle Last James Naylor		15. MOTHER'S MAIDEN NAME First Middle Last Maggie Curtis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 213-05-1257A		17. INFORMANT Address Mrs Gladys WALTER Reisterstown MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4122 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct 8, 1968, to April 14, 1969, that (I) (we) last saw the deceased alive on April 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph E. Bush MD				DEGREE MD		22c. DATE SIGNED April 14, 1969	
22d. PHYSICIAN'S NAME (Type) Joseph E. Bush MD				22e. ADDRESS Layfield, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE April 17, 69		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		23d. LOCATION (City or Town) (County) (State) Boring, Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.				25a. REC'D BY REGISTRAR APR 16 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	





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05254

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05245

1. DECEASED-NAME (Type or print) <b>BIRDIE</b> <b>G.</b> <b>BRASHEARS</b>			2a. DATE OF DEATH <b>April</b> Month <b>28</b> Day <b>1969</b>		2b. HOUR <b>7:45</b> M
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 1, 1880</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (In years last birthday) <b>88</b> YRS.	
10. CITY OR TOWN OF DEATH <b>New Windsor</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>R.D. 2</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. STREET AND NUMBER <b>R.D. 2</b>	
14. FATHER'S NAME <b>Evan</b> <b>Aldridge</b>		15. MOTHER'S MAIDEN NAME <b>Ellen</b> <b>Eury</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Alton R. Brashears</b>		Address <b>Rt. 2</b> <b>Union Bridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>4339</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral thrombosis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>NO</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 5, 1965</b> , to <b>now</b> , 19 <b>1969</b> , that (I) (we) lost the deceased alive on <b>April 26, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>J. H. Caricofe MD</b>		22c. DATE SIGNED <b>April 28, 1969</b>		22d. ADDRESS <b>Union Bridge, Md 21791</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/1/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Linganore Cemetery</b>	
24. FUNERAL DIRECTOR <b>C. M. Waltz, Box 241, Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 1 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Walters Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>05255</div> <div>Item 6 Film 411 4/21/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>05246</div>									
1. DECEASED-NAME (Type or print) <u>Ned</u> <u>CADLE</u> <u>BROOKS</u>					2a. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1969</u>			2b. HOUR <u>11 A</u> M.	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>8-13-1901</u>		6. AGE (In years last birthday) <u>67</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Missouri</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>CARROLL</u> Md.			
10. CITY OR TOWN OF DEATH <u>Sykesville</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Springfield Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Correspondent-Commentator NEWS</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Chevy Chase</u>		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>4103 Oliver Street</u>	
14. FATHER'S NAME First <u>John</u> Middle <u>B.</u> Last <u>Brooks</u>		15. MOTHER'S MAIDEN NAME First <u>Jane</u> Middle <u>-</u> Last <u>Cadle</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <u>No</u>		16b. SOCIAL SECURITY NO. <u>578072159</u>		17. INFORMANT <u>Hospital records</u>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Toxemia secondary to infected decubitus</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Presenile dementia</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>CBS with circulatory disturbance other than arteriosclerosis without qualifying phrase</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-25</u> , 19 <u>68</u> , to <u>4-13</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Suha Ozgun</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-13-1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>SUHA OZGUN</u>		22e. ADDRESS <u>Springfield State Hospital</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE <u>4/14/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GEDAR HILL CREM.</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD.</u>			
24. FUNERAL DIRECTOR <u>SOS. GAWLER'S SONS</u>		ADDRESS <u>5130 WIS. AVE. N.W.</u>		DATE <u>APR 15 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

05255

STATE OF TEXAS

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05256

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05247

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
LESLIE JENNINGS BROWN						4-15-69			1969			2:50 P.M.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR				
MALE	WHITE	JAN. 8, 1908	61 YRS.	MONTHS	DAYS	HOURS	MIN.	Month 4 Day 15 Year 1969			3:00 P.M.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
MARYLAND		U.S.A.				CARROLL CO.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
WESTMINSTER				REAR 105 E. MAIN ST.				CARPENTER							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MARYLAND				CARROLL				WESTMINSTER				REAR 105 E. MAIN ST.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
MILTON SEYMOUR BROWN				FANNIE M. SPENCER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
YES				W.W. II				216-01-9982				MRS. DORIS H. BROWN, WESTMINSTER, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Coronary Thrombosis												Sudden			
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				HOUR A.M. P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				4-15-69							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				105 E. Main St. Westminister, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County)			
BURIAL				4/18/69				MEADON BRANCH CEMETERY				RURAL, WESTMINSTER, MD.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
J.S. Murphy, Westminster, Md.				215				APR 21 1969				Charles Judge			



082526

INFORMATION TO BE FURNISHED TO THE

1. NAME OF THE PERSON OR PERSONS

2. ADDRESS OF THE PERSON OR PERSONS  
3. DATE OF BIRTH  
4. DATE OF DEATH  
5. DATE OF ENTRY  
6. DATE OF EXIT  
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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05248		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) <b>DARE</b>			First Middle Last <b>S BUCHANAN</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>4-24 1969</b>			2b. HOUR <b>12:20</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>3-13-10</b>		6. AGE (In years last birthday) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll</b>			
10. CITY OR TOWN OF DEATH <b>Sykesville</b>				11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) <b>Springfield State</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2615 Hilton St., Baltimore</b>		
14. FATHER'S NAME First Middle Last <b>Andrew G. Buchanan</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Carrie M. Taylor</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Records, Springfield State Hospital, Sykesville</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>423X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>old myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>adhesive constrictive pericarditis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days or wks.</b>  <b>years</b>  <b>months or years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>Epileptic psychosis.</b>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>W. L. Speicher</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>4-24-69</b>				
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE <b>5.2.69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. Schol</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, Md.</b>			
24. FUNERAL DIRECTOR <b>Carroll Funeral Home Pikesville</b>						ADDRESS		25a. REC'D BY REGISTRAR <b>MAY 5 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

05232

MINERAL EXPLORATION, BUREAU OF DEPT. OF THE INTERIOR

RECEIVED

0110

TO THE DIRECTOR, BUREAU OF DEPT. OF THE INTERIOR  
FROM THE CHIEF, MINERAL EXPLORATION  
SUBJECT: [Illegible]  
[Illegible text follows]

[Illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)  
30M REV. 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05258										
CERTIFICATE OF DEATH										
05250										
1. DECEASED-NAME (Type or print) <i>May Coulbourn</i>			2a. DATE OF DEATH <i>April</i> Month <i>20</i> Day <i>1969</i> Year			2b. HOUR <i>8:35</i> P.M.				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Sept. 14, 1887</i>		6. AGE (In years last birthday) <i>81</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i> Md.				
10. CITY OR TOWN OF DEATH <i>Westminister</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll County Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Finksburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Rt # 1</i>	
14. FATHER'S NAME <i>Charles H. Ashem</i>			15. MOTHER'S MAIDEN NAME <i>Mary Wilson</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <i>NO</i> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO. <i>220.12.8748</i>		17. INFORMANT <i>Thomas Coulbourn 1119 Daniels Ave. (7)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>4123</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Heart Disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>April 17, 1969</i> , to <i>April 20, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 20, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.										
22b. SIGNATURE <i>John S. Stansbury, MD</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/20/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>JOHN S. STANSBURY, MD</i>				22e. ADDRESS <i>8 Anson St. Westminster Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/23/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Woodlawn Baltimore Md.</i>				
24. FUNERAL DIRECTOR <i>John I. Stansbury 6411 Windsor Mill Rd.</i>				25a. REC'D BY REGISTRAR DATE <i>APR 23 1969</i>		25b. REGISTRAR'S SIGNATURE <i>W. L. L. L. L.</i>				

052528

STATE OF TEXAS

COUNTY OF DALLAS

IN SENATE,  
January 11, 1950.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE  
TO THE  
SENATE.  
PUBLISHED BY THE  
GOVERNMENT PRINTING OFFICE  
WASHINGTON, D. C. 20540  
1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>William Scott Dayhoff</i>			First Middle Last			2a. DATE OF DEATH Month Day Year <i>April 29 1969</i>		2b. HOUR 8:15 A M	
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>11-30-1890</i>		6. AGE (In years last birthday) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>CARROLL</i> Md.			
10. CITY OR TOWN OF DEATH <i>UNIONTOWN</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>RURAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>EDGE SETTER SHOE MFG.</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>CARROLL</i>		13c. CITY OR TOWN <i>UNIONTOWN</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>RURAL</i>	
14. FATHER'S NAME First Middle Last <i>BENJAMIN DAYHOFF</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>LAURA MAGEE</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not or unknown <i>YES WW I</i>			16b. SOCIAL SECURITY NO. <i>213-05-1586</i>		17. INFORMANT Address <i>DEBORAH B. DAYHOFF UNIONTOWN MD</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocarditis (acute)</i> <i>4450</i> DUE TO, OR AS A CONSEQUENCE OF <i>Myocarditis (acute)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis (Ch)</i> DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerosis (Ch)</i> (c) <i>Coronary artery disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>none</i>									
19a. DATE OF OPERATION <i>3-10-69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Benign tumor of foot</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar - 4, 1969</i> , to <i>4-29-1969</i> , that (I) (we) last saw the deceased alive on <i>3-28-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Wm C. Sennette MD</i>					DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-29-69</i>
22d. PHYSICIAN'S NAME (Type) <i>Wm C. SENNETTE MD</i>					22e. ADDRESS <i>103 E Main Westminster Md 21157</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>5-2-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LUTHERAN CEM. UNIONTOWN MD</i>		23d. LOCATION (City or Town) (County) (State) <i>UNIONTOWN MD</i>			
24. FUNERAL DIRECTOR <i>Wm H. Hulse New Windsor Md</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>MAY 1 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

05260

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05252

1. DECEASED-NAME (Type or print) <b>BESSIE CATHERINE EBBERT</b>			2a. DATE OF DEATH Month <b>Apr</b> Day <b>1</b> Year <b>1969</b>			2b. HOUR <b>11:30 AM</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>SEPT 23, 1884</b>		6. AGE (In years last birthday) <b>84</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.	
10. CITY OR TOWN OF DEATH <b>UNION BRIDGE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>E BROADWAY</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEKEEPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>UNION BRIDGE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>E BROADWAY</b>		14. FATHER'S NAME First <b>ADAM</b> Middle <b>RICKETTS</b> Last <b>GRIMES</b>		15. MOTHER'S MAIDEN NAME First <b>SARAL</b> Middle <b>GRIMES</b> Last <b>GRIMES</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>BETTY MONET</b>		Address <b>UNION BRIDGE MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4124 Arteriosclerotic CVD</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , to <b>4/11/69</b> , that (I) (we) last saw the deceased alive on <b>3/31/49</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>M.E. Robertson MD</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/11/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>M E ROBERTSON</b>				22e. ADDRESS <b>NEW WINDSOR MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/4/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT VIEW</b>		23d. LOCATION (City or Town) (County) (State) <b>UNION BRIDGE MD</b>	
24. FUNERAL DIRECTOR <b>DD Hartzler Sons Union Bridge</b> ADDRESS				25a. REC'D BY REGISTRAR <b>DATE APR 7 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
05261		CERTIFICATE OF DEATH						05253								
1. DECEASED-NAME (Type or print)			First Clara			Middle Maude			Last Erb			2a. DATE OF DEATH Month April Day 27 Year 1969			2b. HOUR 8:45 P	
3. SEX Female			4. RACE White			5. DATE OF BIRTH December 1, 1881			6. AGE (In years last birthday) 87 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Md.							
10. CITY OR TOWN OF DEATH Taneytown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route # 1			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY None							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Carroll			13c. CITY OR TOWN Taneytown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Route # 1				
14. FATHER'S NAME First William			Middle Frounfelter			Last Mary			15. MOTHER'S MAIDEN NAME First Catherine			Middle Myers			Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 217-28-6108D			17. INFORMANT Address William F. Erb R # 1, Taneytown, Md. 21787							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia 2° To Extensive metastatic Lympho-Sarcoma</u> 2001 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Marked Emaciation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lympho-Sarcoma orbit, sinuses</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mo 8 mo 2 yrs																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chemotherapy of Lympho-Sarcoma</u>																
19a. DATE OF OPERATION 4/24/67			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> , 19 <u>67</u> , to <u>4/27</u> , 19 <u>69</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>3/27</u> , 19 <u>69</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.																
22b. SIGNATURE <u>E. Ambler Thompson MD</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>4/28/69</u>							
22d. PHYSICIAN'S NAME (Type) Dr. E. Ambler Thompson						22e. ADDRESS 322 East Balt. St. Taneytown, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 29, 1969			23c. NAME OF CEMETERY OR CREMATORY Grace Reformed Cemetery			23d. LOCATION (City or Town) (County) (State) Taneytown Carroll, Md.							
24. FUNERAL DIRECTOR <u>John M. Skiles</u> ADDRESS C.O. Fuss & Son Taneytown, Md. 21787						25a. REC'D BY REGISTRAR DATE APR 30 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

STATE OF NEW YORK  
IN SENATE  
January 1, 1913  
REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1912  
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS  
1913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1-7-60

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05262					05254				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>MERLE ELIZABETH</b>			First Middle Lost		2a. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1969</b>			2b. HOUR <b>6:40pm</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>MAY 2-1915</b>		6. AGE (In years lost birthday) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.			
10. CITY OR TOWN OF DEATH <b>UNION BRIDGE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ELGER ST.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEKEEPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>UNION BRIDGE</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>ELGER ST (NONE)</b>	
14. FATHER'S NAME First Middle Lost <b>CHARLES EARNST</b>			15. MOTHER'S MAIDEN NAME First Middle Lost <b>MINNIE FOGLE</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-30-3607</b>		17. INFORMANT Address <b>MUNCIE FLORA UNION BRIDGE MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Heart Disease</b> <b>4121</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Hypertensive cardiovascular disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 12</b> 19 <b>64</b> , to <b>now</b> , 19 <b>69</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>April 3</b> 19 <b>69</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> (did) (did not) view the body after death.									
22b. SIGNATURE <b>J. H. Caricofe</b> M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>April 5, 1969</b>			
22d. PHYSICIAN'S NAME (Type) <b>J. H. Caricofe, M.D.</b>				22e. ADDRESS <b>Union Bridge, Maryland 21791</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>APRIL 8-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEAVER DAM</b>		23d. LOCATION (City or Town) (County) (State) <b>UNION BRIDGE RURAL MD</b>			
24. FUNERAL DIRECTOR <b>DD Hutchins Sons Union Bridge</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>APR 11 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>	



02382

CERTIFICATE OF DEATH

WILLIAM H. HARRIS, JR., 1000 1/2 WEST 10TH AVENUE, DENVER, CO.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-68  
30M REV. 1-68

05263		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05255	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Charles B. Godman</i>			First Middle Last		2a. DATE OF DEATH Month <i>April</i> Day <i>26</i> Year <i>1969</i>		2b. HOUR <i>1 A</i> M
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>May 17, 1879</i>		6. AGE (In years last birthday) <i>89</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i> Md.	
10. CITY OR TOWN OF DEATH <i>Taneytown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>RD 1-M</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Machinist-Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Taneytown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <i>John E. Godman</i>		First Middle Last		15. MOTHER'S MAIDEN NAME <i>? Renner</i>		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO. <i>215-01-7860</i>		17. INFORMANT <i>Muriel V. Holbrook</i>		Address <i>Same as # 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ATHEROSCLEROTIC HEART DISEASE</i> <i>4123</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Unknown.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1959</i> , 19____, to <i>Now</i> , 19____, that (I) ( <del>we</del> ) last saw the deceased alive on <i>April 25</i> , 1969, and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>yes</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
22b. SIGNATURE <i>J. H. Caricofe M.D.</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>April 26, 1969</i>	
22d. PHYSICIAN'S NAME (Type) <i>J. H. Caricofe M.D.</i>				22e. ADDRESS <i>N. Main St. Extended Union Bridge, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/29/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR <i>Jhon I. Stansbury</i>				ADDRESS <i>6411 Windsor Mill Rd.</i>		25a. RECD BY REGISTRAR DATE <i>APR 28 1969</i>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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STATE OF DEATH

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon/papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR	
Lillian Hays Garrett GORRELL				April 11, 1969		6:15 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
female		white		5-29-91		77 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		U.S.A.				Carroll Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville		Springfield State Hosp.		Housewife		INDUSTRY -----	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Carroll		Westminster		Rt. 1111 3 Box 320 A	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last			
William Garrett				Sarah Knight			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
no		UNKNOWN		Redords Springfield State Hospital, Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart failure due to recent myocardial infarct.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4109</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>CBS assoc. with circulatory disturbance other than cerebral arteriosclerosis with psychotic reaction.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <u>9-12-62</u> , 19 <u>  </u> , to <u>4-11-69</u> , 19 <u>  </u> , that (I) <del>(we)</del> last saw the deceased alive on <u>4-11-69</u> , 19 <u>  </u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Alfredo M. Labrit</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-11-1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>Alfredo M. Labrit, M.D.</u>				22e. ADDRESS <u>Springfield State Hospital Sykesville, Maryland 21784</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Burial</u>		<u>4/15/69</u>		<u>Meadowridge Memorial Pk</u>		<u>Elkridge, Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert P. Ware</u>				ADDRESS <u>Singleton Funeral Home/Glen Burnie.Md.</u>		25a. REC'D BY REGISTRAR <u>APR 14 1969</u> DATE	
						25b. REGISTRAR'S SIGNATURE <u>William Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
OLIVER			R. HARRISON			April 8 1969			530 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Male		White		Jan. 16, 1880		89 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Mt. Airy		507 N. Main St.		Retired-Farmer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Carroll		Mt. Airy				507 N. Main St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Nimrod Harrison			Sally Watkins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			220-09-7849		Morley W. Harrison Same As #13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>								20 years	
4124 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) _____ DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									
22a. I certify that (I) (this hospital) attended the deceased from _____, 1950, to April, 1969, that (I) (we) last saw the deceased alive on April 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
W.B. Culwell, M.D.									April 8, 1969
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
W.B. Culwell					900 So. Main Mt. Airy, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/10/19 69		Pine Grove		Mt. Airy, Carroll, Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
C. M. Waltz, Box 241, Sykesville, Md.					APR 10 1969		V. Charles Jones		

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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05258

1. DECEASED-NAME (Type or print) <b>Emma Mae Hecker</b>			2a. DATE OF DEATH Month <b>04</b> Day <b>24</b> Year <b>69</b>			2b. HOUR <b>2:00</b> P. M.
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>04-1-87 88</b>		6. AGE (In years last birthday) <b>81 88</b> YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>Birth - U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.		
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore City Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>3510 Parklawn Ave.</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>Bosserman</b> Last <b>Hess</b>			15. MOTHER'S MAIDEN NAME First <b>Katherine</b> Middle <b>Hess</b> Last <b>Hess</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records, Springfield State Hospital, Sykesville Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforation of left ventricular wall</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Thrombosis of left coronary artery</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Day to week</b> <b>Day to week</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>11-20-62</b> , 19____, to <b>4-24-69</b> , 19____, that (I) (we) last saw the deceased alive on <b>4-24-69</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Dr. Antonius Glahn</b> DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/25/69</b>
22d. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M. D.</b>				22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/28/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25a. READ BY REGISTRAR <b>APR 28 1969</b> 25b. READ BY SIGNATURE <b>[Signature]</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
FREDERICK RUTTER JACKSON						April 6 1969		12:25 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		WHITE		JULY 15, 1886		82 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Phila. Pa.		U. S. A.				CARROLL Co.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
WESTMINSTER		CARROLL Co. GEN. HOSP.		SALESMAN						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND		CARROLL		WESTMINSTER				601 OLD BALTO BLVD.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
ANDREW JACKSON			HESTER RUTTER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
NO			216-05-1309			MRS. MARIAN B. REDMILE			17 SHIRLEY RD. NARBETH, PA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) 1621 DUE TO, OR AS A CONSEQUENCE OF										
(b) Bronchogenic Carcinoma 1 yr.										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from Mar 30, 1969, to April 6, 1969, that (I) (we) last saw the deceased alive on April 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John S. Harshey, M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/6/69		
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.						22e. ADDRESS 8 Anchor St. Westminster, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		4/10/69		WESTMINSTER CEMETERY		WESTMINSTER, MD.				
24. FUNERAL DIRECTOR L. S. Myers Jr., Westminster, Md.						25a. REC'D BY REGISTRAR APR 10 1969		25b. REGISTRAR'S SIGNATURE J. Charles Jorgie		

05287

IN CHARGE OF UNIT

CHIEF OF UNIT

UNIT NO.

05287

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05268 CERTIFICATE OF DEATH 05260									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
FRANCIS BERNARD JAWORSKI						Month Day Year APRIL 8, 1969		12:25 A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		9-4-01		67 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Poland		U.S.A.				Carroll Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville			Springfield State Hospital			Lab technician			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Baltimore City Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5331 Maple Ave.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Francis Jaworski			First Middle Last Unk.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			Unk.		Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>485X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction (Parkinson's signs).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-30-65</u> , 19____, to <u>4-8-69</u> , 19____, that (I) (we) last saw the deceased alive on <u>4-8-69</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>Octavio A. Ruiz</u>								4-8-69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Octavio A. Ruiz, M. D.				Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12 APR 69		St. Stanislaus Cemetery		Chicopee, Massachusetts			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Starzyk Funeral Home 81 Center St. Chicopee, Mass				APR 14 1969		<u>Charles Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4)  
30M REV. 7/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05269						05261					
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
First Middle Last Louisa J. Jefferson						Month Day Year April 27, 1969			12:05 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Nov. 5, 1899		89 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Carroll Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			7 Grandview Ave.			Housewife			Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Carroll		Sykesville				Grandview Ave		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
John - Eckert				Unk.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No -				-		Mrs. Leona Burman Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT - C B A</u> <u>4/21</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension, ASHD, Arteriosclerosis, generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Bronchial pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF <u>1967</u> <u>1969</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 1967, to April, 1969, that (I) (we) last saw the deceased alive on April 27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Howard E. Hall								4/28/69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
Howard E. Hall, M. D.				Sykesville, Maryland 21784							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		4-30-69		Old Oakland Cemetery		Sykesville				Md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. RECD BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Harry W. Haight				Sykesville, Md.		MAY 2 1969		Charles Judge			

05250

EXHIBIT OF DATA

UNION OF THE LAKES - NEW YORK STATE RAILROADS - 1901

1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05270				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05262					
Item 8 Film 413 6/20/69 kk				CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH Month Day Year				2b. HOUR P M	
Jesse				James Jett				4 - 5 - 69				6:30 M	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Male		White		3/27/1900				69 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.	
Virginia		U.S.A.				Carroll							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Sykesville		Springfield State Hosp.		Freight Conductor									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
Maryland		Howard		Ellicott City									
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
Carter B. Jett				Carrie O'Sullivan									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address									
NO		218-07-3029		Hospital Records - Sykesville, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4123</u> <u>PHLEGMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> <u>unful</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> <u>years</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>3/12</u> , 19 <u>65</u> , to <u>4/5</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/5</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Gracie K. Patricia</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4/5/69</u>							
22d. PHYSICIAN'S NAME (Type) <u>GRACIE K. PATRICIA</u>				22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		4-10-69		Good Shepherd		Ellicott City, Howard Md							
24. FUNERAL DIRECTOR <u>Higginbotham Slack</u>		25a. REC'D BY REGISTRAR <u>Ellicott City</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>APR 14 1969</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 11-66

05271		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05263	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <b>MARTIN JOSEPH KAVANAUGH IV</b>			2a. DATE OF DEATH Month <b>APRIL</b> Day <b>19</b> Year <b>69</b>		2b. HOUR <b>8:15</b> P.M.		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>SEPT-5, 1954</b>		6. AGE (In years lost birthday) <b>14</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO. MD.</b>	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER RD #7</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Tyrone Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE <b>MD.</b>		13b. COUNTY <b>CARROLL WESTMINSTER</b>		13c. CITY OR TOWN <b>TYRONE ROAD</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Lost <b>MARTIN J. KAVANAUGH III.</b>			15. MOTHER'S MAIDEN NAME First Middle Lost <b>DOROTHY HENRY</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MARTIN J. KAVANAUGH RD #7, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia Secondary to Convulsions</b> <b>7802</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Terminal Aspiration of Gastric Contents</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Terminal</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Terminal</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Patient known to have generalized seizure 3 1/2 years. Treatment under</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (his hospital) attended the deceased from <b>July</b> , 1967, to <b>April</b> , 1969, that (I) (we) last saw the deceased alive on <b>15 April</b> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dean H. Griffin</b>				22c. DATE SIGNED <b>19 April 69</b>		22d. PHYSICIAN'S NAME (Type) <b>DEAN H. GRIFFIN</b>	
22e. ADDRESS <b>RIDGE ROAD WESTMINSTER, MD</b>				22f. ADDRESS <b>RIDGE ROAD WESTMINSTER, MD</b>		22g. ADDRESS <b>RIDGE ROAD WESTMINSTER, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/21/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOW BRANCH CEM. WESTMINSTER RD. MD.</b>		23d. LOCATION (City or Town) (County) (State) <b>WESTMINSTER MD.</b>	
24. FUNERAL DIRECTOR <b>J.S. Major, A. Westminster, Md.</b>				25a. REGISTERED BY <b>APR 21 1969</b>		25b. REGISTERED BY SIGNATURE <b>J.S. Major</b>	

17830

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05272		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05264	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <b>ALMETA</b>			First Middle Last <b>KESSEE</b>		2a. DATE OF DEATH Month Day Year <b>APRIL 7 1969</b>		2b. HOUR <b>1:40 A.M.</b>
3. SEX <b>FEMALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>8-3-30</b>		6. AGE (In years last birthday) <b>38</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b>	
10. CITY OR TOWN OF DEATH <b>SYKESVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRINGFIELD STATE HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>DOMESTIC</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER <b>831 CENTRAL AVENUE</b>							
14. FATHER'S NAME First Middle Last <b>EDWARD EVANS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>FLORENCE CROWNER</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>330-22-1722</b>		17. INFORMANT Address <b>RECORDS, SPRINGFIELD STATE HOSPITAL</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis, Far Advanced</b> <b>011.2</b> DUE TO, OR AS A CONSEQUENCE OF <b>Active</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus, Schizophrenia</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>9-10-68</b> , 19____, to <b>4-7-69</b> , 19____, that (I) (we) last saw the deceased alive on <b>4-7-69</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Jose A. Raquel J. M.D.</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/7/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Jose A. Raquel J. M.D.</b>				22e. ADDRESS <b>Springfield State Hosp</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>3-13-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT CALVARY CEM</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto Md Md</b>	
24. FUNERAL DIRECTOR <b>Elsa O. Wilson</b>				25a. REC'D BY REGISTRAR <b>APR 14 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	

0825

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05273					05265				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Radie					Kelbaugh	April Month 10, Day 1969			10:30
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
Female		White		Sept. 9, 1873		95 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		USA				Carroll Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Silver Run			Meadow View Nursing Home			Housewife			Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.		Upperco,			Old Hanover Rd.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Alexander			Marsh			Rachael Ann			Osborn
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
NO			217-54-9826		Mrs. George Osborn				Upperco, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissection</u> 2699 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 5 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1968</u> , to <u>April 10, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 1, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Julius Chapiro</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/11/69</u>		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 14, 1969		Pleasant Grove Cem.		Upperco, Md.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Tipton - Eline Funeral Home					Hampstead, Md.		DATE APR 15 1969		<u>William J. Judge</u>

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05274

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05266

1. DECEASED-NAME (Type or Print) <b>JOHN RAYMOND KELLEY</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>4</b> Day <b>12</b> Year <b>69</b>			2b. HOUR <b>5:30</b> M <b>P</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>June 23, 1891</b>	6. AGE (In years last birthday) <b>77</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>4</b> Day <b>12</b> Year <b>1969</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>		
10. CITY OR TOWN OF DEATH <b>Mt. Airy</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>609 S. Main St.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Lumber Yard Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Mt. Airy</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>609 S. Main St.</b>
14. FATHER'S NAME First <b>Jeremiah</b> Middle <b>Franklin</b> Last <b>Kelley</b>			15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>Burrall</b> Last <b>Burrall</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>214-03-5254</b>		17. INFORMANT <b>Mrs Sadie I. Kelley</b>			ADDRESS <b>Mt. Airy, Md. 609 S. Main St.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun wound Left Chest</b> DUE TO, OR AS A CONSEQUENCE OF <b>Self Inflicted</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <b>5:30 P.M. 4/12 1969</b>		21c. HOW INJURY OCCURRED (Enter nature of injury on Part 2, item 18.) <b>Shot self in Left Chest with Shotgun</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>at Home</b>		21f. LOCATION Street or P.E.D. No. City or Town County State <b>609 South Main Mt Airy Carroll Md</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquest <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>4-12-69</b>		
EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>4/15/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove</b>		23d. LOCATION (City or Town) (County) (State) <b>Mt. Airy, Md.</b>	
24. FUNERAL DIRECTOR <b>Olin L. Molesworth</b>			ADDRESS <b>Damascus, Md.</b>			25a. REC'D BY REGISTRAR <b>APR 16 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

85274

EXAMINER'S RECORD OF TESTS

JOHN J. WILSON, JR.

Date: June 23, 1941

Control

Reaction

600 N. Main St.

Mr. J. W.

600 N. Main St.

Mr. J. W.

Reaction

Reaction: Normal

600 N. Main St.

Mr. J. W.

Reaction: Normal

Reaction: Normal

600 N. Main St.

Reaction: Normal



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24-hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05275									
05267									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
LEO			BERNARD KERN			Month Day Year APRIL 18, 1969			8:45 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		5-14-06		62 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
W. Va.		U.S.A.				Carroll Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Sykesville			Springfield State Hospital			Laborer			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Washington		Harpers Ferry		Rural		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
George R. Kern			Daisy Barbara Merit						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			236-14-8064		Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Bronchopneumonia, right lung</u> Days									
453X DUE TO, OR AS A CONSEQUENCE OF <u>Extensive interstitial hemorrhage in left thigh &amp; left extraperitoneal abdominal area, probably due to</u> Days or Week									
DUE TO, OR AS A CONSEQUENCE OF <u>Ruptured thrombotic femoral &amp; iliac vein</u> Days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>8-27-68</u> , 19 <u>  </u> , to <u>4-18-69</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>4-18-69</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Octavio A. Ruiz</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-18-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Octavio A. Ruiz, M.D.</u>					22e. ADDRESS <u>Springfield State Hospital Sykesville, Maryland 21784</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/21/69		Fairview Cemetery		Bolivar, Jefferson, W. Va.			
24. FUNERAL DIRECTOR <u>HARRY W. HAIGHT F.H.</u>					ADDRESS <u>HAIGHT F.H. Sykesville, Md.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
							DATE <u>APR 22 1969</u>		<u>William J. Yager</u>

77528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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45M - 1/69

05276		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05268											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR									
DANIEL			FRANKLIN	KIFER	Month 4 Day 23 Year 69		6:40 A										
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR									
Male		Caucasian		06/17/1896		72 YRS.		MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.									
Maryland		U.S.A.				Carroll											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
Sykesville		Springfield State Hosp.		Coal Miner		Mining											
13a. USUAL RESIDENCE (Where deceased lived or admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER											
Maryland		Garrett		Swanton		Rt. 1 Swanton, Md											
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last						
David			Kifer	Elizabeth	Shipaway												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address								
no			236-01-8051A			Hospital Records											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of lung										mths							
1621 DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis										yrs.							
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
CBS associated with cerebral arteriosclerosis with psychotic reaction																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
22a. I certify that (this hospital) attended the deceased from 2/19/1969, to 4/23/1969, that (he) last saw the deceased alive on 4/23/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Suha Ozgun, M. D.												22c. DATE SIGNED 4/23/69					
22d. PHYSICIAN'S NAME (Type) Suha Ozgun, M. D.												22e. ADDRESS Springfield State Hospital					
23a. BURIAL, CREMATION, or other disposition (Specify) Burial												23b. DATE 4/26/69		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial		23d. LOCATION (City or Town) Cumberland (County) Md. (State)	
24. FUNERAL DIRECTOR E. J. Boral												25a. REC'D BY REGISTRAR DATE APR 25 1969		25b. REGISTRAR'S SIGNATURE			
ADDRESS Westernport, Md.																	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05277

CERTIFICATE OF DEATH

05269

1. DECEASED-NAME (Type or print) <b>Pauline</b>			First	Middle	Last	2a. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>69</b>			2b. HOUR <b>6:30</b> <sup>a</sup> <sub>M</sub>		
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>2-3-04</b>		6. AGE (In years last birthday) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County</b> Md.					
10. CITY OR TOWN OF DEATH <b>Sykesville, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address). <b>Springfield St. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerical work</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>clerical</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balt. City</b>		13c. CITY OR TOWN <b>Balt. City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1 Maple Drive</b>		
14. FATHER'S NAME <b>Theodore</b>			First	Middle	Last	15. MOTHER'S MAIDEN NAME <b>Emma</b>			First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>unk.</b>		17. INFORMANT <b>Medical Records</b> Address <b>Springfield State Hosp., Sykesville, M.D.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>707.0</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Multiple Robert ulcers</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Schizophrenia Parot. Scapli 1 ype</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10-16-56</b> , 19 <b>69</b> , to <b>2-22</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2-22</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE <b>G. Sagisi, M.D.</b>						DEGREE <b>MD</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>G. Sagisi, M.D.</b>						22e. ADDRESS <b>Springfield State Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-24-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mountford Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>					
24. FUNERAL DIRECTOR <b>Karey W Haight</b>				ADDRESS <b>Sykesville Md.</b>		25a. REC'D BY REGISTRAR <b>APR 25 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages Lead 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05278

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05270

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <b>RUTH OTHELLO LONG</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>4</b> Day <b>3</b> Year <b>1969</b>			2b. HOUR <b>5:00</b> P.M.		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Aug. 25, 1909</b>	6. AGE (In years last birthday) <b>59</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b>	OAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>4</b> Day <b>3</b> Year <b>1969</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>		
10. CITY OR TOWN OF DEATH <b>Keymar</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route # 1</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Bakery worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Baking</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Keymar</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Route # 1</b>		
14. FATHER'S NAME First <b>William</b> Middle <b>Elias</b> Last <b>Stitely</b>			15. MOTHER'S MAIDEN NAME First <b>Maude</b> Last <b>Otto</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>216-05-0985</b>		17. INFORMANT <b>Mrs. Maude Stitely, R # 1 Keymar, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis (acute)</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>4-3-69</b>		
EXAMINER'S NAME (Type) <b>W. Glenn Speicher</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Charles J. Judge</b>			22c. DATE SIGNED <b>APR 7 1969</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Apr. 6, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Middleburg Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Middleburg, Carroll, Maryland</b>		
24. FUNERAL DIRECTOR <b>John H. Skiles</b>				ADDRESS <b>C.O. Fuss &amp; Son</b>		25a. REC'D BY REGISTRAR <b>Charles J. Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>

03237

MEMORANDUM FOR THE RECORD

TO: THE CHIEF OF BUREAU

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1-59

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05279 CERTIFICATE OF DEATH 05271									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Harold Seiss Mehring						April 2, 1969			4:20 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		November 7, 1892			76 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland		U.S.A.					Carroll Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Taneytown			E. Baltimore Street			Livestock Broker			Cattle
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Carroll		Taneytown				E. Baltimore Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
David M. Mehring			Mary E. Basehoar						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			215-34-1890			Dr. Richard Mehring, Kensington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4109</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Few Min.</u> <u>1 year</u> <u>10 years</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>10/23, 1958</u> , to <u>4/2, 1969</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>4/1, 1969</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
22b. SIGNATURE <u>R.S. McVaugh (M.D.)</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/2/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>R.S. McVaugh</u>					22e. ADDRESS <u>Taneytown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		Apr. 5, 1969		Lutheran Cemetery			Taneytown, Carroll Co., Md.		
24. FUNERAL DIRECTOR <u>John H. Skiles</u> ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
C.O. Fuse & Son Taneytown, Maryland					DATE <u>APR 7 1969</u>		<u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05280										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05272									
1. DECEASED-NAME (Type or print) <b>James S MILLER</b>										2a. DATE OF DEATH 4 Month 10 Day 67 Year										2b. HOUR 5:30 AM									
3. SEX Male					4. RACE Colored					5. DATE OF BIRTH 10-16-92					6. AGE (in years last birthday) 76 YRS.					IF UNDER 1 YEAR MONTHS 3 DAYS 10 HOURS 5 MIN					IF UNDER 24 HRS. MIN				
7a. BIRTHPLACE (State or foreign country) Dist of Col					7b. CITIZEN OF WHAT COUNTRY? American					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH CARROLL Md.														
10. CITY OR TOWN OF DEATH Sykesville Md.					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield St. Hosp					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 14130005					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.					13b. COUNTY BALTIMORE					13c. CITY OR TOWN BALTIMORE					13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 816 No. Fairview Ave									
14. FATHER'S NAME First Middle Last John Miller					15. MOTHER'S MAIDEN NAME First Middle Last Lucy Ann																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO. 212-10-1987A					17. INFORMANT Address Hospital Rm 1111 Springfield St. Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Disease</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Brain Syndrome associated with arteriosclerosis without qualifying phrase</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 1-8-69, to 3-10-69, that (I) (we) last saw the deceased alive on 3-10-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE J. C. Murphy, M.D.					DEGREE ATTENDING PHYS.					MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 3/10/69														
22d. PHYSICIAN'S NAME (Type) J. C. Murphy, M. D.					22e. ADDRESS Springfield State Hospital																								
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE 4-14-1969					23c. NAME OF CEMETERY OR CREMATORY Mt Auburn					23d. LOCATION (City or Town) (County) (State) Baltimore														
24. FUNERAL DIRECTOR Mortimer P. Langer					ADDRESS 235 W. Green St					25a. REC'D BY REGISTRAR DATE APR 14 1969					25b. REGISTRAR'S SIGNATURE J. Charles Judge														



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ESTIMATE OF CHARGE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05273

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Jacob C Monath</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1969</b>			2b. HOUR <b>3:40</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>1/24/1891</b>		6. AGE (In years last birthday) <b>78</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Pa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.	
10. CITY OR TOWN OF DEATH <b>Manchester</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Long View Nursing Home 1234 Main St</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Lineboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First <b>George</b> Middle <b>Monath</b> Last <b>Monath</b>		15. MOTHER'S MAIDEN NAME First <b>Lamanda</b> Middle <b>Wildasin</b> Last <b>Wildasin</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>yes WW I</b>		16b. SOCIAL SECURITY NO. <b>214-03-6535</b>		17. INFORMANT <b>Mrs Jacob Monath</b> Address <b>Lineboro Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> <b>5710</b> DUE TO, OR AS A CONSEQUENCE OF <b>Lactones urthous</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Antemortem Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>4 days</b> <b>5 days</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>pulmonary emphysema - Diabetes mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>48</b> , to <b>April 14, 1969</b> , that (I) (we) last saw the deceased alive on <b>3/11</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>W. H. Foard M.D.</b> DEGREE <b>W. H. Foard M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/14/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>W. H. Foard M.D.</b>				22e. ADDRESS <b>Manchester, Md 21102</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 16, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lineboro Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lineboro, Carroll Md.</b>	
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 16 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

02520

552-2410

100-443887-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05274	
05282										05274	
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M		
GEORGE KOONTZ MORELOCK						APRIL 7-1969			6:00 A.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		5-18-1881			87 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.				CARROLL					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life-even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
WESTMINSTER			ROUTE 2			TRUCKER-FARMER-RET					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			CARROLL			WESTMINSTER		RURAL			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
GEORGE MORELOCK			LYDIA								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
NO			NO			216-30-2809			MRS ADDIE B. COOK, ROUTE 2 WESTMINSTER MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>about 4 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>none</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <u>none</u>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr. 7</u> , 19 <u>68</u> , to <u>Apr. 7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Apr. 5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>C. H. Billingslea M.D.</u>			22c. DATE SIGNED <u>4-9-69</u>								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
C. H. Billingslea M.D.			Westminster, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County)		
BURIAL			4-10-69			LEISTERS CEM.			WESTMINSTER MD.		
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
D. D. Hatcher & Sons			New London Md.			APR 11 1969			[Signature]		

02520



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

05283

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05275

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> ESTIMATED	Month	Day	Year	2b. HOUR	
WALTER JACOB NEWMAN						4-22			<input type="checkbox"/>	4	22	1969	10:10 A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR		
MALE	WHITE	JAN. 20, 1898		71 YRS.	MONTHS DAYS		HOURS MIN.		Month 4 Day 22 Year 1969			10:15 A M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
MARYLAND		U.S.A.				CARROLL CO.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY				
WESTMINSTER		CARROLL CO. GENERAL HOSP.				SALESMAN				LIQUOR STORE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER						
MARYLAND		CARROLL CO.		WESTMINSTER		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		511 E. MAIN ST.						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
NOAH			C.		NEWMAN	MARY JANE					KRUMRINE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
NO			217-03-4179			MRS. HELEN B. NEWMAN			ADDRESS SAME					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Skull													2 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) Self Inflicted														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					21b. TIME OF INJURY Month, Day, Year 8:00 A.M. 4-22-69					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot Self in Head with 38 cal Pistol				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) His Home					21f. LOCATION Street or R.F.D. No. City & Town County State 511 E Main Westminister Carroll Md				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE					W. L. Speirches					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)					155 E Main Westminister Carroll					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
										22b. DATE SIGNED 4-22-69				
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE 4/25/69					23c. NAME OF CEMETERY OR CREMATORY WESTMINSTER CEM.				
BURIAL										23d. LOCATION (City or Town) (County) WESTMINSTER CARROLL, MD				
24. FUNERAL DIRECTOR					ADDRESS					25a. RECEIVED BY REGISTRAR				
J. S. Myroff, Westminister, Md.										DATE APR 25 1969				
										25b. REGISTRAR'S SIGNATURE				
										Ruben Judge				

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RECEIVED BY THE DIRECTOR OF THE FBI  
JAN 10 1964

WILLIAM J. BROWN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-48

05284		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05276	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) <b>ELMER EDWARD NUSBAUM</b>			2a. DATE OF DEATH <b>April 25 1969</b>		2b. HOUR <b>10:15 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>DEC. 15-1892</b>		6. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>CARROLL</b> Md.		
10. CITY OR TOWN OF DEATH <b>UNION BRIDGE</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ELGER ST</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>OPERATOR</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>TAVERN</b>		
13a. USUAL RESIDENCE (Where deceased lived 11 institution: Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>CARROLL</b>	13c. CITY OR TOWN <b>UNION BRIDGE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>ELGER ST.</b>	
14. FATHER'S NAME First Middle Last <b>SOLOMON NUSBAUM</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>FANNIE GARBER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes-no, or unknown) <b>YES MORAD WAR I</b>		16b. SOCIAL SECURITY NO. <b>216-05-3389</b>	17. INFORMANT Address <b>ELSIE W. NUSBAUM UNION BRIDGE MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4124 Arteriosclerotic CVD</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>Diabetes Mellitus, Ventral hernias</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>1949</b> , 19____, to <b>4/25/69</b> , 19____, that (I) <del>have</del> saw the deceased alive on <b>4/23/69</b> , 19____, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>(did not)</del> view the body after death.					
22b. SIGNATURE <b>M.E. Robertson MD</b> DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>4/25/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>M.E. ROBERTSON</b>			22e. ADDRESS <b>New Windsor, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4-28-69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. VIEW CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>UNION BRIDGE MD.</b>	
24. FUNERAL DIRECTOR <b>D.W. Harkness</b>		ADDRESS <b>UNION BRIDGE MD.</b>		25a. RECD BY REGISTRAR <b>APR 28 1969</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

1982

1. The purpose of this document is to provide a summary of the information received from the source regarding the activities of the group in the area of [redacted] and [redacted].

2. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

3. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

4. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

5. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

6. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

7. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

8. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

9. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

10. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted]. The source has provided information regarding the activities of the group in the area of [redacted] and [redacted].

CONFIDENTIAL - SECURITY INFORMATION  
EXCLUDED FROM AUTOMATIC DOWNGRADING AND DECLASSIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05285

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05277

1. DECEASED-NAME (Type or print) <b>Sadie Mae Putman</b>			2a. DATE OF DEATH <b>April</b> Month <b>4</b> Day <b>1969</b> Year			2b. HOUR <b>7:10</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 14, 1886</b>		6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.			
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Co. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Taneytown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RD 1</b>	
14. FATHER'S NAME First Middle Last <b>John Monroe Light</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Amanda Lay master</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-24-3729D</b>		17. INFORMANT Address <b>Mrs. Wilson Myers Taneytown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Bronchopneumonia</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>April 2, 1969</b> , to <b>April 4, 1969</b> , that (I) (we) last saw the deceased alive on <b>April 4, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John S. Harshey, MD</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/4/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY, MD</b>				22e. ADDRESS <b>8 Archer St. Westminster, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-7-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church of Brethren C.</b>		23d. LOCATION (City or Town) (County) (State) <b>Rocky Ridge Fred Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b> ADDRESS <b>Thurmont, Md.</b>				25a. REC'D BY REGISTRAR <b>App</b> DATE <b>8 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>			

02282

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

OFFICE OF THE ASSISTANT ATTORNEY GENERAL  
WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05286		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05278			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Elsie</i> First <i>C.</i> Middle <i>Reymann</i> Last			2a. DATE OF DEATH Month <i>4</i> Day <i>11</i> Year <i>69</i>			2b. HOUR <i>10:45</i> M.			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>4/15/80</i>		6. AGE (In years last birthday) <i>88</i> YRS.			
7a. BIRTHPLACE (State or foreign country) <i>Switzerland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>CARROLL</i> Md.			
10. CITY OR TOWN OF DEATH <i>SYKESVILLE</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>PULLEN NSG. HOME</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> COUNTY <i>—</i>			13b. CITY OR TOWN <i>Baltimore</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2911 Westfield Ave</i>		
14. FATHER'S NAME First <i>Joseph</i> Middle <i>Henggeler</i> Last			15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>Maria</i> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <i>NO</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>215-01-4922</i>		17. INFORMANT <i>Mr M Alphons Reymann</i>			Address <i>Same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4109</i> (b) <i>Generalized Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Terminal Pneumonia</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>20 yrs</i> <i>3 days</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hemiplegia Rt. Arm. Brain Syndrome</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>June 14, 1968</i> , to <i>4.11.1969</i> , that (I) (we) last saw the deceased alive on <i>4.10.1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Sani Okutman</i>				DEGREE <i>Sani Okutman</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4.11.69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Sani Okutman</i>				22e. ADDRESS <i>Sykesville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/14/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR <i>Leonard J Ruck Inc. Baltimore, Maryland</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE <i>APR 14 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	

02886

OFFICE OF THE

U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D.C. 20250

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

DATE: 12-1-77  
BY: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>HARRY WILSON SARKER</b>			First Middle Last			2a. DATE OF DEATH <b>April 6 1969</b>			2b. HOUR <b>7:30 P.M.</b>		
3. SEX <b>MALE</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Nov 2 - 1881</b>			6. AGE (In years last birthday) <b>87</b>		
7a. BIRTHPLACE (State or foreign country) <b>Somerset Pa</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll</b>		
10. CITY OR TOWN OF DEATH <b>Westminster MD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>(Rural)</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>State Highway Dept</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Pd</b>			13b. COUNTY <b>Somerset Co</b>			13c. CITY OR TOWN <b>Berlin Pa</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>1506 E Main St</b>			14. FATHER'S NAME <b>John Sarker</b>			15. MOTHER'S MAIDEN NAME <b>Matchless FLANN</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/>		
16b. SOCIAL SECURITY NO. <b>161-18-5800</b>			17. INFORMANT <b>Mrs. Mahel Shaffer</b>			Address <b>Westminster - 13th St</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 19 <b>67</b> , to <b>April 6</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>April 3</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W. H. Foard M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>4/6/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>W. H. Foard M.D.</b>			22e. ADDRESS <b>Manchester Md 21102</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>4/9/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Berlin Pa.</b>		
24. FUNERAL DIRECTOR <b>J. S. Myers, Jr.</b>			ADDRESS <b>Westminster, Md.</b>			25a. REC'D BY REGISTRAR <b>DAAP 10 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Michaela Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
TRUMAN WILSON SAUBLE						Month 4 Day 27 Year 69			37 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		WHITE		JAN. 3, 1894		75 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				CARROLL CO.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
WESTMINSTER			CARROLL Co. GEN. HOSP. TRUCK DRIVER							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			CARROLL		WESTMINSTER		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8 MAPLE AVE.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
WESLEY E. SAUBLE			IRENE			KOONTZ				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address				
NO			217-01-7224							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) 4109 CORONARY THROMBOSIS									IMMED.	
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) ATHEROSCLEROTIC CORONARY HEART DISEASE									YEARS	
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
CHRONIC OBSTRUCTIVE PULMONARY DISEASE										
DIABETES MELLITUS										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from 4/18, 1969, to 4/27, 1969, that (I) (we) last saw the deceased alive on 4/27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
22b. SIGNATURE						22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		4/30/69		ST. JOHN'S CEMETERY		WESTMINSTER, MD.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
J.S. Myers, Jr. Westminster, Md.		MAY 2 1969		Charles Judge						

8850

WALSH 10-27-49

11/10/49

11/10/49

05289

05281

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	2b. HOUR M	
Effie		Ray		Senseny <del>Sansensky</del>	April		4	1969	7:30	
3. SEX Female		4. RACE White		5. DATE OF BIRTH October 23, 1874		6. AGE (In years last birthday) 94		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll		Md.		
10. CITY OR TOWN OF DEATH Union Bridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route # 1		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Union Bridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route # 1		
14. FATHER'S NAME First Middle Last Manassa Repp		15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Pfoutz		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Marshall Senseny, Union Bridge, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATHEROSCLEROTIC Heart Disease</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral Atherosclerosis; Hypostatic Pneumonia</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>April 14, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 4, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>J.H. Caricofe M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>April 4, 1969</u>				
22d. PHYSICIAN'S NAME (Type) J.H. Caricofe		22e. ADDRESS Union Bridge, Maryland 21791								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Uniontown, Carroll Co., Md.				
24. FUNERAL DIRECTOR C.O. Fuss & Son		ADDRESS John H. Skiles		25a. REC'D BY REGISTRAR Taneytown, Maryland		25b. REGISTRAR'S SIGNATURE APR 7 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FORM NO. 10  
REVENUE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05290

05282

1. DECEASED-NAME (Type or print) <b>EDNA MAY SMITH</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1969</b>			2b. HOUR <b>24 M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>OCT. 16 - 1885</b>		6. AGE (In years last birthday) <b>83 YRS.</b>		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b>			
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>319 E. MAIN ST</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEKEEPING</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>319 E. MAIN ST.</b>	
14. FATHER'S NAME First <b>HARRY</b> Middle <b>SMITH</b> Last			15. MOTHER'S MAIDEN NAME First <b>SALLY</b> Middle <b>SHUEY</b> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-38-8648</b>		17. INFORMANT <b>MYRTLE S. SMITH</b> Address <b>319 E. MAIN ST WESTMINSTER MD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>undetermined</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes, arteriosclerosis, senility.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1949</b> , 19____, to <b>4/23/69</b> , 19____, that (I) <del>was</del> <b>did</b> saw the deceased alive on <b>4/13/69</b> , 19____, and that in <del>my</del> <b>our</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <b>did</b> (did not) view the body after death.									
22b. SIGNATURE <b>M.E. Robertson MD</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/23/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>M.E. ROBERTSON</b>				22e. ADDRESS <b>New Windsor, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4-25-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>CARROLL COUNTY MD</b>			
24. FUNERAL DIRECTOR <b>D. H. Hubert</b>				ADDRESS <b>NEW WINDSOR MD</b>		25a. REC'D BY REGISTRAR <b>APR 24 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

*Proctor, Arthur*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Lottie Barron Smith</b>						2a. DATE OF DEATH Month <b>4</b> Day <b>4</b> Year <b>69</b>			2b. HOUR <b>9:35</b> M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7-13-1870</b>		6. AGE (In years last birthday) <b>98</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.					
10. CITY OR TOWN OF DEATH <b>Sykesville</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> 13b. COUNTY <b>Balto. City</b>				13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>808 Madison Ave.</b>			
14. FATHER'S NAME First <b>Jacob</b> Middle <b>Strub</b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b>Sally</b> Middle <b>Wilkerson</b> Last <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war and dates of service)				16b. SOCIAL SECURITY NO. <b>220-54-662 2</b>		17. INFORMANT Address <b>Sykesville Maryland</b> <b>Springfield Hosp. Records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome, Ass'd. with cerebral arteriosclerosis without psychotic reaction.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>reaction.</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>7-20-62</b> , 19 <b>62</b> , to <b>4-4-69</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4-4-69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Charles R. Patricia</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4-4-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>GPAC' to R. PATRICIA</b>						22e. ADDRESS <b>Springfield State Hosp. Sykesville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-8-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Baltimore Md.</b>					
24. FUNERAL DIRECTOR <b>John T. Stansbury, Sr. - 6414 Windsor Mill Rd.</b>						25a. REC'D BY REGISTRAR <b>APR 7 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

19024

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE

TO THE SECRETARY OF AGRICULTURE  
WASHINGTON, D.C.  
FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing agricultural matters, possibly related to plant industry or pest control.]

RECEIVED  
[Illegible text in the right margin, possibly a date or reference number.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
CECIL WALDO SMOOT										APRIL 22, 1969										11:00																																							
3. SEX Male										4. RACE White										5. DATE OF BIRTH 10-9-16										6. AGE (In years last birthday) 52										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Virginia										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Carroll										Md.																			
10. CITY OR TOWN OF DEATH Sykesville										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Odd Jobs										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. CITY OR TOWN Montgomery										13c. CITY OR TOWN See across										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER NO FIXED ADDRESS																			
14. FATHER'S NAME Samuel O. Smoot										15. MOTHER'S MAIDEN NAME Mary M. Williams										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. Unk.										17. INFORMANT Records, Springfield State Hospital																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive hemorrhage of left jugular vein</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Erosion of vein by carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Extensive carcinoma of central &amp; left side of neck</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1959										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes										Minutes										Months																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>10-2-68</u> , 19 <u>  </u> , to <u>4-22-69</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>4-22-69</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Octavio A. Ruiz										22c. DATE SIGNED 4-22-69																																																	
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.										22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 4/26/69										23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem. Bladensburg Rd Md										23d. LOCATION (City or Town) (County) (State)																													
24. FUNERAL DIRECTOR W.W. Chambers, Inc										25a. REC'D BY REGISTRAR APR 28 1969										25b. REGISTRAR'S SIGNATURE Richard Judge																																							

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05293

## CERTIFICATE OF DEATH

05285

1. DECEASED-NAME (Type or print) <b>First</b> <del>Marie</del> <b>Mary</b> <b>Middle</b> <del>Marie</del> <b>Marie</b> <b>Last</b> <b>Springirth</b>			2a. DATE OF DEATH <b>4</b> Month <b>15</b> Day <b>69</b> Year		2b. HOUR <b>7:45</b> AM
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>11/19/98</b>		6. AGE (In years last birthday) <b>70</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll</b> Md.		
10. CITY OR TOWN OF DEATH <b>Rural--Sykesville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Kensington</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>3700 Farragut Street</b>	
14. FATHER'S NAME <b>Charles</b> <b>Meneat</b> <del>Menear</del>	15. MOTHER'S MAIDEN NAME <b>Agnes</b> <b>Oatz</b> <del>Datz</del>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			
16b. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Carl B. Springirth</b> Address <b>3700 Farragut St</b> <del>Springfield State Hospital, Sykesville, Maryland</del> <del>Kensington, Maryland</del>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>4270</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Depressive reaction</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/19/</b> , 19 <b>65</b> , to <b>4/15/</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4/15/</b> 19 <b>69</b> , and that in <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <del>(do not)</del> view the body after death.					
22b. SIGNATURE <b>Naci N. Buyukunsal</b>	22c. DATE SIGNED <b>4/15/69</b>	22d. PHYSICIAN'S NAME (Type) <b>Naci N. Buyukunsal, M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 18, 1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>Glen Carter</b>	25a. REC'D BY REGISTRAR <b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		26. DATE <b>APR 21 1969</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

05294

05286

1. DECEASED-NAME (Type or print) <b>Emma J. Study</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1969</b>			2b. HOUR <b>6:30</b> <sup>A</sup> <sup>M</sup>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6/28/1898</b>		6. AGE (In years last birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.				
10. CITY OR TOWN OF DEATH <b>Md. Mailing</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mr. Taneytown- Address Littlestown, Pa. R.D. 1</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife-Housework</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Taneytown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Mailing Address <b>Littlestown, Pa. R. D. 1</b>		
14. FATHER'S NAME First <b>Henry</b> Middle <b>Messinger</b> Last <b>Messinger</b>			15. MOTHER'S MAIDEN NAME First <b>Eliza</b> Middle <b>Unger</b> Last <b>Unger</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-22-8057</b>		17. INFORMANT <b>Ralph W. Study, Littlestown, Pa. R. D. 1</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2509 Hypertensive Heart disease with</b> DUE TO, OR AS A CONSEQUENCE OF <b>cardiac failure</b> (b) <b>arteriosclerosis generalized</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>degenerative</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>hypertensive disease</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>5 yrs</b> <b>20 yrs</b>	
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>April</b> Day <b>28</b> Year <b>1969</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 1962</b> , to <b>April 28, 1969</b> , that (I) (we) last saw the deceased alive on <b>April 26, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>George E. Thomas, M.D.</b>				22c. DATE SIGNED <b>4-28-69</b>		22d. PHYSICIAN'S NAME (Type) <b>George E. Thomas, M.D.</b>				
22e. ADDRESS <b>110 Hoyer Rd. Pa.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/1/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Nr. Littlestown, Adams Co. Pa.</b>				
24. FUNERAL DIRECTOR <b>Richard A. Little</b>				25a. REC'D BY REGISTRAR <b>MAY 1 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Richard A. Little</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10:00 20:00 30:00 40:00 50:00 60:00 70:00 80:00 90:00 100:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05287

1. DECEASED-NAME (Type or print) First Middle Last <b>George Herman VON DREELE</b>			2a. DATE OF DEATH Month Day Year <b>April 11, 1969</b>			2b. HOUR <b>11:00 P.M.</b>					
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>11-2-92</b>		6. AGE (In years last birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>—</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1200 Valley St.</b>			
14. FATHER'S NAME First Middle Last <b>John H. Von Dreele</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Katherine Lehr</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Records</b> Address <b>Springfield State Hospital, Sykesville, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>months</b> <b>years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>CBS with cerebral arteriosclerosis with psychotic reaction.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (this hospital) attended the deceased from <b>8-5-63</b> , 19__, to <b>4-11-69</b> , 19__, that (X) (we) last saw the deceased alive on <b>4-11-69</b> , 19__, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Gracito V. Patricio</b>				DEGREE <b>—</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/11/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>GRACITO V. PATRICIO</b>				22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/14/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>				
24. FUNERAL DIRECTOR <b>Henry W. Jenkins</b>		ADDRESS <b>4905 York Rd Baltimore 12, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 14 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

sent query to informant, Sykesville, 5/13/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05296 CERTIFICATE OF DEATH 05288									
1. DECEASED-NAME (Type or print) George R. E. Weitzel			2a. DATE OF DEATH April Month 29 Day 1969 Year			2b. HOUR 10:30M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 12, 1898		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Unknown		7b. CITIZEN OF WHAT COUNTRY? ✓		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Woodbine		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nursing Home Owner-retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Woodbine		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 216-05-1159		17. INFORMANT Address Sykesville, Md. James A. Hall, Box 299, Rt. 4				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, ASHD, Arteriosclerosis,</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF <u>generalized, questionable abdominal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aneurysm.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1960</u> <u>April</u> <u>1969</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>  </u> , to <u>April</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 9, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Howard E. Hall</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/29/69</u>			
22d. PHYSICIAN'S NAME (Type) Howard E. Hall, M. D.				22e. ADDRESS College Ave. Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/2/1969		23c. NAME OF CEMETERY OR CREMATORY Good Sheppard		23d. LOCATION (City or Town) (County) (State) Howard, Md.			
24. FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md.				25a. REC'D BY REGISTRAR MAY 2 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05297

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05289

1. DECEASED-NAME (Type or print) <b>GLADYS MAY WIMERT</b>			2a. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>1969</b>			2b. HOUR <b>A</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUG. 27, 1900</b>		6. AGE (In years lost birthday) <b>68</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>BALTO. MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL Co.</b>	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>67 W. Main St.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>NEWSPAPER EXECUTIVE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL Co.</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>67 W. MAIN ST.</b>		14. FATHER'S NAME First <b>LEWIS N.</b> Middle <b>CHENOWETH</b> Last <b>MARY</b>		15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>PARSONS</b> Last <b>PARSONS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>217-01-7204</b>		17. INFORMANT <b>LESTER WIMERT</b>		Address <b>WESTMORELAND ST. WESTMINSTER MD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV. 1954</b> , to <b>APRIL, 1969</b> , that (I) (we) last saw the deceased alive on <b>APRIL 27, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Daniel I. Welliver</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4-27-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>DANIEL I. WELLIVER</b>		22e. ADDRESS <b>MD 9 RIDGE ROAD WESTMINSTER MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>5/1/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTMINSTER CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WESTMINSTER MD</b>	
24. FUNERAL DIRECTOR <b>J.S. Myers, Jr. Westminster, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>MAY 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

70520

STATE OF TEXAS  
COUNTY OF DALLAS

BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_

known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05298

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05290

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR 8:00 AM	
PETER						WOLF		4-29 1969		8:00 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	
Male	White	Nov. 19, 1910		58 YRS.						4 Day 29 Year 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Maryland		U.S.A.				Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		R.D. 6				Maintenance		Shoe Factory			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Carroll		Westminster				Route 6			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
George						Wolf		Lillie		Naner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		WW 2		219-03-2136		Mrs. Rhoda V. Wolf		Same As #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation (By Hanging)</u> 953X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 8:00 AM 4-29 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Hanged Self in Cellar of Home					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State Rd 6 Mullards Westminster Carroll Md							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-29-69			
		Dr. W. Glenn Speicher				135 E Main Westminster Carroll, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)					
Burial		5/2/1969		Trinity Lutheran		Carroll, Md.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
C. M. Waltz, Box 241, Sykesville, Md.						MAY 2 1969		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
JOHN SUMMERVILLE YOUNG						Month Day Year APRIL 11, 1969		2:00 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		1-5-07		62 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Carroll Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Auto mechanic				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Baltimore City		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1437 Roland Heights Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last John S. Young, Sr.			First Middle Last Nettie Baublitz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
No			216-10-5415		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Scleroderma</u> 7340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CBS, other diseases of unknown or uncertain cause (scleroderma), with psychotic reaction										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>10-1-65</u> , 19__, to <u>4-11-69</u> , 19__, that (I) (we) lost the deceased alive on <u>4-11-69</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. Antonius Glahn</u>					22c. DATE SIGNED <u>4/11/69</u>		22d. PHYSICIAN'S NAME (Type) Antonijs Glahn, M.D.			
22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4, 14, 69		Moreland Mem.		Balto. Md.				
24. FUNERAL DIRECTOR Paul E. Chenoweth 3rd. 3617 Chenoweth Ave.					25a. REC'D BY REGISTRAR DATE APR 15 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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